Dental Medicaid Seminar Registration Form

June 2007 Dental Medicaid Seminar
Registration Form
(No fee)

Provider Name _____

Medicaid Provider Number_____NPI Number_____

Mailing Address_____

City, Zip Code_____County_____

Contact Person_____ E-mail_____

Telephone Number(____)_____ Fax Number_____

1 or **2** person(s) will attend the seminar at_____ on _____
(circle one) (location) (date)

Please fax completed form to: 919-851-4014
Please mail the completed form to:
EDS Provider Services
PO Box 300009
Raleigh, NC 27622